evolve *
CHIROPRACTIC & WELLNESS CENTRE

Meghan Barnes RD, CDE
Registered Dietitian
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Dietitian Patient Intake

*denotes R Macdonald Professional Corporation

First Name _____ Last Name _____ Emergency Contact Name and Number _____

Address _____ City _____ Postal Code _____

Cell Phone _____ Work Phone _____ Home Phone _____

Occupation _____ Email (I agree to receive appointment reminders and clinic updates) _____

Birthdate (dd/mm/yr) _____ Gender _____ Marital Status _____ Alberta Health Care Number _____

Family Doctor _____ Last Physical Exam _____

For your convenience, we can keep a credit card on file:

Card Type: ☐ Visa ☐ Mastercard Number:_____-_____-_____-_____ Expiry:____/____ CCV: _____

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name _____ Group ID/Policy Number _____ Member Number _____

Relationship to Cardholder (self, spouse, child) _____ Name of Cardholder _____

Have you ever had:

☐ AIDS
Hepatitis
☐ A ☐ B ☐ C
☐ Other blood-borne disease_____

Health Priorities/ Chief Concerns:

List your main health concerns in order of importance:

1. _____
2. _____
3. _____

MEDICAL HISTORY

Please indicate any serious illnesses, conditions, or reasons for hospitalization.

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement/Brand	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please indicate any allergies and/or food sensitivities.

Allergy/Food Sensitivity	Symptoms

FAMILY HISTORY

Please indicate whether **you or your immediate family members** have or had the following:

Condition	Who?	Condition	Who?	Condition	Who?
Alchoholism		Cancer Type:		Depression	
Allergies				Osteoporosis	
Alzeimers		Drug Addiction		Parkinsons	
Arthritis Type:		Diabetes Type:		Seizure/Epilepsy	
				Stroke/Aneurysm	
Asthma		Eczema/Psoriasis		Thyroid Condition Type:	
Autoimmune Disease Type:		Heart Disease			
		Kidney Disease		Tuberculosis	
HIV/AIDS		Liver Disease		Other	

Informed Consent for Dietetic Care

Meghan Barnes RD, CDE

PLEASE READ AND INITIAL EACH SECTION BEFORE SIGNING BELOW.

Consent to Treatment

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications. It is important that you inform your practitioner immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding.

I understand that my Registered Dietitian will answer any questions that I have to the best of his/her ability. I understand that results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and complications. I will rely on the practitioner to exercise judgment during the course of my treatment which s/he feels is in my best interest based on the facts which are known**.**

With this knowledge I voluntarily consent to the treatment recommended to me by my practitioner. I intend for this consent to apply to all my present and future Dietetic Care.

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INITIALS

Privacy

In compliance with the Personal Information Protection and Electronic Documents Act (PIPEDA), information collected by Evolve Chiropractic and Wellness Centre will be used solely by Evolve Chiropractic and Wellness Centre and will not be sold or shared with any third party without written consent from the client.

Evolve Chiropractic and Wellness Centre is the information holder. You may request your information at any time by contacting Evolve Chiropractic and Wellness Centre directly.

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INITIALS

Extended Health Coverage

Many extended healthcare insurance plans cover Registered Dietitian services. For privacy purposes, Evolve Chiropractic and Wellness Centre cannot access details of individual insurance plans. Please contact your insurance provider for details of your coverage.

When possible, Evolve Chiropractic and Wellness Centre offers direct billing for your convenience.

_____
INITIALS

Credit Card Holder Authorization

I, the previously-named authorized credit card user, give Evolve Chiropractic and Wellness Center express authorization to charge my credit card for the purposes of 1) Payment for services rendered by any practitioner at Evolve Chiropractic and Wellness Center. 2) Payment for goods purchased from any practitioner at Evolve Chiropractic and Wellness Center. 3) Payment for any outstanding balance I may incur. I understand that this form constitutes a legally binding contract and that by affixing my signature to this form, I will be held responsible for all agreed upon (as stated above) charges as well as any and all collection and legal fees. This credit card is authorized for only the charges noted above.

_____
INITIALS

IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.

Dated this_____ day of_____, 20_____.

_____ _____

Patient Signature (or Legal Guardian) Dietitian Signature